29 July 1968

MEMORANDUM TO: Chief, Benefits and Services Division

SUBJECT : Comments on Mutual of Omaha's Paper re Health Insurance Plans as Requested by DD/Pers/SP

1. The comments enclosed with Conway's letter of 12 July, as they speak to comparison of benefits of the three plans by benefit areas, are true as general broad statements. They are essentially what we stated verbally in our 21 May meeting with Al Randall. They are about all anyone could expect from a broad general summary of the plans' approaches to benefit structure. However, they do not point out the countless minute ways in which the plans differ. These differences may be considered minute in Mutual's somewhat philosophical discourse on the benefit approach of these three plans, but they loom quite large in the mind of an individual claimant when he becomes aware of how his particular claim could have been paid under one of the other plans. Let me illustrate with two examples. First, excision of impacted teeth. Aetna pays regular benefits for "excision of impacted teeth that are not completely erupted." Blues pays if "for hospitalized bed patients." GEHA excludes surgical charge, but will pay for hospital charges if confined. Second example is removal of plantar wart from the foot by a podiatrist. Blues brochure would indicate coverage of removal by cutting, chemicals or electrodesiccation. Several readings of page 8 of Aetna's brochure still leave me wondering about their position. GEHA covers podiatrist's charges for this surgery only if it involves "incision through the true skin." However, if this surgery is performed by an M.D., GEHA covers it regardless of method employed. (There are other Federal plans, underwritten by Mutual, which cover this surgical charge of a podiatrist, even if done by the chemical or electrodesiccation procedure.) These seem like very minor points - except to the claimant when he finds out that another plan would have covered the charge when his plan does not. In his eyes, that one minor point makes the other plan "better" or "best." I belabor this matter for two reasons. It typifies the attitude of the average individual in evaluating his plan, and it indicates the near impossibility of a complete comparison of three different plans. (It also points out the issues in which our claims personnel get involved and why we are accused of being petty, bureaucratic, and picayunish in our requirements to substantiate a claim.)

2. I get the overall impression from Mutual's comments that

they are made for two purposes - to defend the GEHA Plan and to proclaim the noble cause of insurance companies to "hold the line" on hospital and medical costs. My reaction on the first point is that we do have a good plan, but we cannot say ours is "best" (nor can any other) and we should not close our eyes to the fact that it can be improved. I also take exception to the statement that "Less than $99,000 in health care costs came out of the pocket of GEHA insureds in 1967." In my own case, each of my family members incurred major medical expenses, but they were not sufficient to meet the deductible and therefore were not submitted as a claim. I am sure a big majority of us had similar experience to a greater or lesser degree, but these expenses are not taken into account in that $99,000 figure. I do not make this observation for the purpose of abolition of the deductible, but rather to point out the fallacy of the "out of pocket" statement. On the matter of holding the line on hospital and medical cost, I am sure everyone but the medical profession is in agreement. But disagreement arises when we talk about who is going to "hold the line" and by what means. When an employee submits his own claim, he is not interested in the purpose of a deductible, dollar limitations, co-insurance, or "protection of the premium dollar" - he wants his bills paid by his insurance. Doctors and hospitals take the attitude, "these are our charges - we don't care how you, the patient, come up with the money, so long as they are paid." Insurance companies say construct the benefit provisions so that the insured bears some part of the cost and thereby force him to be interested in how much or how little he is charged. As an employee organization plan, we say let's have a plan which bests satisfies the overall needs and desires of our particular group. As I see it, we, as GEHA, are caught somewhere in the middle. And when we think of the influence our Plan's benefits have on the nation or the metropolitan area on hospital room and board cost, or surgical fees, or the price of an office visit, it amounts to spit in the ocean.

3. I think the federal employee health insurance plans are caught in a dilema for which there is no solution - competition has been the cause. Health insurance is no longer viewed as insurance. I would again like to illustrate this, my personal view, with another example. How often do you hear someone complain because he did not collect anything on the fire insurance on his house or collision insurance on his car? He doesn't because it takes a fire or an accident in order to file a claim and he is glad it did not happen. However, it is common to hear the complaint that "I paid out X dollars on my health insurance last year and got little or nothing for it." I suppose this is only a natural human reaction when health insurance plans are adding more and more first dollar benefits for the type of expenses that we can all expect to incur. But my understanding of the purpose of insurance in general is that it is to protect against the unexpected. To provide first dollar coverage for such expenses

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is nothing more than swapping dollars and the total insured population of a plan is the loser because it costs money in the form of administrative expenses to process claims. The plan is not going to lose because it simply raises rates to match cost. Unfortunately, one plan adds a new wrinkle to attract new members. Others follow suit or add their own gimmick as a counter measure. The end result is increased premium to pay for new benefits which are not really insurance. But I am now being more philosophical than Mutual. The hard facts of life are that you cannot take away a benefit, once given - you cannot ignore what other plans are offering. Example: "Why don't we pay regular benefits for maternity like Aetna and the Blues?" is a big complaint among our Plan's members. As an answer, I doubt if they will be very receptive to Mutual's statement - "This is in part due to the fact that a maternity admission is neither an accident nor an illness. Neither does it represent an unforeseen loss since several months of planning will precede the admission; the insured is to be encouraged to budget ahead for his own expense, due to the particular nature of this case." Very true but very unpalatable.

4. One final word about Mr. Conway's suggestion that they send one of their claim administrators into our office to work with us on changes and eliminations of procedures as a means to cut operation costs. I think it would be most enlightening to both parties. I am sure their claims administrator could give us some pointers and I am also sure he will return to his office thankful that he does not have our headaches. I am not so sure how many of his suggestions we would be able to adopt.

5. In summary, neither Mutual's comments nor my own persuade me that we should abandon the idea of a study directed at restructuring our plan. To the contrary, I think this should be done.

[redacted]
Chief, Insurance Branch STAT

C/BSD	19 July 1968	RLA 69-10

Letter from Conway re Association Plan dated 12 July w/note to ask C/IB to analyze material and submit comments, etc.

FORM 11-58 44C OBSOLETE PREVIOUS EDITIONS

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Remarks:

Please ask C/IB to analyze this material and to let me have his comments, be they good or bad. Depending on his review, I will want to consider sending a copy of this study to each Board member.

FOLD HERE TO RETURN TO SENDER

FROM: NAME, ADDRESS AND PHONE NO.	DATE
DD/Pers/SP	19 JUL 1968

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your good neighbor
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WASHINGTON, D.C., REGIONAL GROUP OFFICE
SUITE 1208, 1730 PENNSYLVANIA AVE., N.W.
WASHINGTON, D.C. 20006
298-8084

NORMAN C. CONWAY
MANAGER

July 12, 1968

STAT

[redacted] President
Government Employees Health Assn.
Post Office Box 463
Washington, D.C. 20044

STAT

Association Plan

Dear [redacted]

I believe you will find the enclosed comments concerning the Blue Cross, Aetna, and Association Plan of considerable interest. The comments are, of course, based on the 1968 Association Plan.

The GEHA Board's recent decision to amend the contract in 1969 to provide full semi-private benefits for the first 90 days of hospital confinement brings your group closer to the Blue Cross approach and concurrently puts the contract into the cost spiral area. We are, of course, aware of the reasons behind this decision and realize also that you are aware of the loss of cost control that will accompany this contract change. The Board in their wisdom, however, did leave some degree of cost control, namely, limiting this benefit to the first 90 days as compared to Blue Cross' one year.

We feel that such carefully thought out changes, as those proposed this year and in past years, has given your program a distinct personality of its own, in that it is tailor-made to meet the specific needs of your membership as such needs are made known. The recently expressed opinion that the plan has grown "haphazardly" or has been put together piece-meal is, in our opinion, an unfair criticism of a well developed program and one designed specifically for GEHA by GEHA.

STAT

July 12, 1968

It's possible that this program has resulted in an uneconomical operation, as far as claim payments are concerned. The only way this can be determined would be to send some of our "claim administrators" into your office to actually work with your people to discover what, if any, procedures could be changed or eliminated.

Sincerely,

N. Conway

Norman C. Conway
Regional Manager

NCC:sak
Encl.

BENEFIT COMMENTS - BLUE CROSS, AETNA AND THE ASSOCIATION PLAN

This comparison has been undertaken to show how three health care programs offered to government employees differ in their approach to solution of the problem confronting the consumer: namely, how can health care protection best be provided to guard against catastrophic loss while the insurance premium dollar is protected against unwarranted depletion by abuse or overuse.

Of concern are plans provided government employees by Aetna, Blue Cross-Blue Shield and Mutual of Omaha's GEHA program. It is clear from extensive studies made of the GEHA claim experience for 1966 and for 1967 that the most important criterion by which an insurance program can be judged, the adequacy of benefits, has been successfully met. In 1966, 97.3% of charges were paid as benefits; in 1967, 95.9% of charges were paid as benefits. The small decline in percentage of total charges paid is a result of hospital-medical inflation in 1967.

Less than $99,000 in health care costs came out of the pocket of GEHA insureds in 1967 while more than $2,305,000 was paid by the program. The adequacy of the benefit structure having been shown, the question of premium protection becomes paramount. Premium protection serves the interests of both insurer and insured so this aspect of program evaluation should not just be considered from the side of one party to the insurance contract.

When premium protection can exist, and it can be shown statistically that there is little, if any, financial harm to the insured, the proper balance between benefit adequacy and protection of the premium dollar has been

HOSPITAL ROOM AND BOARD

Room and board expenses accounted for slightly more than one-fourth of the GEHA dollars in 1967, so this category represents a significant portion of the insurance program. It should be clear that premium protection is better assured by limited benefits of a specified amount than by full or virtually unlimited benefits.

The GEHA plan offers up to $40 a day for 90 hospitalized days, with 80% of charges in excess of $40 for a semi-private room. Statistics show that 97% of hospital admissions are for 31 days or less, and that the percentage that reaches 90 days will be of almost no significance. The January ASP rate in the Washington area was $42.69, so the greatest part of the room and board charge is paid by the GEHA program.

When it can be shown that an indemnity program for a specified number of days will produce a benefit level that will cover the great majority of expenses, the necessity for or desirability of a 365 day service type plan providing ASP benefits comes under serious question. The Blue Cross-Blue Shield approach, thus, provides no ceiling on costs, or in fact any incentive for a ceiling on costs. Just the opposite is indeed the case.

The Aetna approach is geared to payment of the first $1,000 of room and board costs each calendar year, and 80% of the excess for semi-private only. This means, in effect, 23 hospitalized days at the current ASP rate -- and this would cover almost all admissions.

In summary, the GEHA approach seems far more likely to exert a cost controlling influence on hospital inflation simply because there is less reason for the hospitals to increase rates. Despite -- and because of -- the close relationship between Blue Cross and the hospitals there is little

evidence that the "service" organization will effect any positive results on holding the line on hospital costs. Rather, a more positive influence -- although indirect -- can be made by commercial insurance companies through various insurance industry associations.

HOSPITAL MISCELLANEOUS

This item presents the largest single coverage in terms of benefits to the insured, more than 28% for GEHA in 1967.

The three plans under comparison offer different views of the approach to the payment of hospital miscellaneous expenses. Blue Cross offers a full coverage benefit for 365 days in a member hospital. Once again, there is no restraining influence on inflationary pressures. On the other extreme, the Aetna plan pays a flat 80% on an 80-20 coinsurance basis. This plan calls for a direct cost to all hospitalized claimants, and for some the burden may be unduly harsh.

A middle ground approach is taken by the GEHA program underwritten by Mutual. For this plan there is full miscellaneous coverage for 90 days, and 80% coverage thereafter. Thus, an element of premium protection exists. Most claimants will have their full miscellaneous costs paid for, however.

HOSPITAL OUTPATIENT

Similar to their inpatient miscellaneous plans, the three plans offer different approaches to the payment of outpatient benefits. The Blue Cross plan offers full coverage for treatment of accident or emergency illness. The Aetna plan offers a 80% payment for these services on a coinsurance basis.

As with hospital inpatient expenses, the GEHA plan offers a middle ground approach. The GEHA plan pays $202.50 per accident or illness, which should amount to full coverage for the great majority of cases, plus 80% of the excess.

SURGICAL

Both Blue Shield and the GEHA plan offer the same approach to surgical benefits. For each a surgical schedule allowance is made for each procedure, plus the plan pays 80% of excess charges over that allowance.

The Aetna plan, in contrast, pays a flat 80% of surgical charges and presents a less favorable benefit plan from the viewpoint of the insured.

MATERNITY

Maternity benefits provide another area where a contrasting approach has been taken in the three plans. The Aetna plan provides for hospital benefits on the same basis as any illness or injury. This pays nearly all hospital charges, but disallows protection of the premium dollar by placing realistic limits on this coverage.

The Blue Cross plan pays full basic hospital and surgical-medical benefits. Obstetrical benefits are scheduled. Once again, with full hospital services paid there is little incentive or encouragement to cut costs to the program and to protect the premium dollar.

The GEHA plan once more offers a more controlled cost program and one that is better qualified to curb depletion of the premium dollar. Up to $30 a day is allowed for hospital charges for up to 8 days. Nearly all maternity admissions are five days in length or less. In addition, the obstetrical benefits are specified in the contract.

While providing a much more controlled cost approach, the GEHA plan accurately pays a much smaller portion of the cost of the maternity admissions than do the other two. This is in part due to the fact that a maternity admission is neither an accident nor an illness. Neither does it represent an unforeseen loss since several months of planning will precede the admission; the insured is to be encouraged to budget ahead for his own expense, due to the particular nature of this case.

NON-SURGICAL MEDICAL CARE

Both Aetna and the GEHA plan operate on a 80%-20% coinsurance basis for this coverage. The Blue Shield approach provides for a basic schedule allowance plus 80% of excess charges over the schedule allowance.

OTHER MEDICAL SERVICES AND SUPPLIES

All three plans operate on an 80%-20% coinsurance basis for this coverage.

OUT OF HOSPITAL X-RAY & LAB

As with most other coverages, the Aetna approach is coinsurance on an 80%-20% basis. The Blue Cross plan uses a scheduled allowance plus payment of 80% of excess charges. The GEHA approach uses a $75 per calendar year area of full payment, then 80% of charges over that amount.

MENTAL AND NERVOUS

All three plans provide their standard benefits for hospital confinement. The GEHA plan specified outpatient medical services which are compensable and the allowance for each visit.

SUMMARY

The best interests of all parties to the insurance contract are served, as stated above, when an adequate benefit structure is in force and -- at the

same time -- there are contractual provisions that will maximize the value of the premium dollar. Inflationary frills and unnecessarily unlimited benefits serve to weaken the insurance package rather than to strengthen it. While the appeal of full coat coverage for the insured cannot be denied, this should be counter-balanced by knowledge that such coverages tend to lower the value of the premium dollar rather than raise it.

On an overall basis, it seems that a desirable balance between benefit levels and premium predictability is contained in the GEHA plan. Its benefits are intended to provide superior protection to the insured and the fact that almost 96% of charges were paid as benefits last year indicates this goal has been achieved. Yet the GEHA plan does not encourage the claimant to seek unusually luxurious treatment, nor is there an invitation for the provider of services to inflate charges as is the case with strictly "open" benefits.

The structure of the Blue Cross-Blue Shield systems eliminate the possibility of a more positive approach to premium protection. Controlled by the providers, rather than the purchasers, of health services, the Blue Cross-Blue Shield system requires groups to conform to their inflation-geared system rather than gearing their system to the needs of the group. Through the avoidance of taxes and the unfair shifting of costs through the discount or rebate system, the Blues enjoy an advantageous position over commercial insurance companies. Yet the latter provide the sounder approach to the solution of health care problems at lowest cost to the insured.